



CHANGE FORM

Medica DirectSM for Individuals

Send completed form to:

Use this form to indicate changes to your member information, add newborn or adopted children, terminate dependents or cancel your coverage. Other additions to enrollment or changes in benefits must use application form. Please print clearly with a blue or black pen.

Medica
Mail Route CP320
PO Box 9310
Minneapolis, MN 55440-9310

A. SUBSCRIBER INFORMATION (THIS SECTION MUST BE COMPLETED)

First Name	M.I.	Last Name	Birth Date	Social Security Number
			/ /	
Current Member I.D. Number	Home Telephone		Work Telephone	
-	()		()	

B. MEMBER CHANGES

Change Address to:

Street Address _____ City _____ State _____ Zip _____

Change Name from: _____ to: _____

C. CHANGE IN COVERAGE

Addition(s) in dependent child coverage: <input type="checkbox"/> Newborn (Date of Birth) <input type="checkbox"/> Adoption (Date of Placement) Date Effective: ____ / ____ / ____	Termination(s) of coverage: Reason (check one): <input type="checkbox"/> Dependent ineligible <input type="checkbox"/> Moved outside service area <input type="checkbox"/> Term all coverage <input type="checkbox"/> Death <input type="checkbox"/> Other: _____ Effective date of termination: ____ / ____ / ____
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Change	First Name	M.I.	Last Name	Relationship	Sex	Birth Date	Social Security Number
<input type="checkbox"/> Add					M	/ /	
<input type="checkbox"/> Term					F	/ /	
<input type="checkbox"/> Add					M	/ /	
<input type="checkbox"/> Term					F	/ /	
<input type="checkbox"/> Add					M	/ /	
<input type="checkbox"/> Term					F	/ /	

D. SUBSCRIBER AUTHORIZATION & REPRESENTATION – Read this section, date and sign the form.

I authorize, on behalf of any additional dependent child(ren) enrolled on this form, the use of a Social Security Number for purpose of identification. I understand that I may revoke this authorization by notifying Medica in writing. If I revoke the authorization, it will not affect any actions already taken by Medica prior to Medica's receipt of the revocation. Information used or disclosed pursuant to this authorization will remain subject to Medica's privacy standards. I understand that I have the right to review Medica's Privacy Notice before signing this form and to request a copy at any time.

The information provided on this form is accurate and complete. I understand and agree that any omissions or incorrect statements knowingly made on this form may invalidate my or my dependent's coverage.

I understand that my premium may be impacted by the change(s) requested on this form. I will be responsible for any additional premium amount due from the date coverage starts. I understand that any refund will be returned to me.

Subscriber Signature: **X** _____ Date Signed: _____

A person who submits a change form or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

OFFICE USE ONLY

Effective Date of Change	Reviewed by	Date	New Group Number	Premium Change
/ /				<input type="checkbox"/> Y <input type="checkbox"/> N